NON-PASS THROUGH MARKET BASKET CLASSIFICATION
(Excluding Wages and Benefits)

MARKET BASKET CATEGORIES	PRICE INDICATORS	
	VARIABLE	SOURCE
(1) Professional Fees for Physicians	Physicians' services component	Consumer Price Index, Urban Consumers
(2) Other Professional Fees	Hourly earnings production or non supervisory, private nonagricultural employees	U.S. Department of Labor, Bureau of Labor Statistics
(3) Food	Average of processed foods and feeds component of PPI and food and beverages component of CPI	Producer Price Index Consumer Price Index All Urban Consumer
(4) Drugs	Pharmaceuticals and ethicals component	Producer Price Index
(5) Other costs: (a) Chemicals	Chemicals and allied products component	Producer Price Index
(b) Surgical & Medical Instruments and Supplies	Special industry machinery and equipment component	Producer Price Index
(c) Rubber and Plastics	Rubber and plastics	Producer Price Index
(d) Travel	Transportation component	Consumer Price Index All Urban Consumers
(e) Apparel and Textiles	Textile products and apparel component	Producer Price Index
(f) Business Services	Services component	Consumer Price Index All Urban Consumers
(g) All Other	All items	Consumer Price Index All Urban Consumers

b) The price index shall be 1.0 + the percentage increase in each price category as measured by the price indicator, expressed as a proportion.

8) The formula for the hospital IPI shall be:

IPI = (PX1 * PGE1) + (PX2 * PGE2) +
(PX3 * PGE3) + (PX4 * PGE4) +
(ASWI * PGE5) + (AEBI * PGE6) +
(PXO * PGE7)

Where:

IPI = Input Price Index.
PX1 = Price Index for Medical Professional Fees.
PX2 = Price Index for Other Professional Fees.
PX3 = Price Index for Food Costs.
PX4 = Price Index for Drug Costs.
ASWI = Adjusted Salary and Wage Index.
AEBI = Adjusted Employee Benefit Index.
PXO = Price Index for Other Costs.
PGE1 = Proportion of non-pass-through GOE which is for Medical Professional Fees for the prior fiscal period.
PGE2 = Proportion of non-pass-through GOE which is for Other Professional Fees for the prior fiscal period.
PGE3 = Proportion of non-pass-through GOE which is for Food Costs for the prior fiscal period.
PGE4 = Proportion of non-pass-through GOE which is for Drug Costs for the prior fiscal period.
PGE5 = Proportion of non-pass-through GOE which is for Salary and Wages for the prior fiscal period.
PGE6 = Proportion of non-pass-through GOE which is for Employee Benefits for the prior fiscal period.
PGE7 = Proportion of non-pass-through GOE which is for Other Costs for the prior fiscal period.
non-pass-through GOE = GOE minus total of all pass-through costs for the prior fiscal period.

9) Providers that do not supply the data needed to calculate the IPI, shall have an IPI equal to the hospital market basket increase as calculated by HCFA, for the closest corresponding time period. For hospitals with short FPEs, the closest corresponding time period shall be the one with the closest mid-point.

J. A volume adjustment shall be made to the provider's non-pass-through portion of the ARPD for the settlement fiscal period if the number of annualized total hospital discharges in the provider's settlement fiscal period differs from the number of

annualized total hospital discharges in its prior fiscal period. The volume adjustment is used to allocate fixed costs on a per discharge basis. Provider fiscal periods (both settlement and prior) under 360 or over 370 days shall be annualized to a 365 day period based on the following formula:

ATHD = (365/DFP) * THD.

Where:

ATHD = Annualized total hospital discharges.
DFP = Days in fiscal period.
THD = Total hospital discharges.

1) The volume adjustment shall be calculated using the following formula which adjusts the rate per discharge for estimated changes in average costs resulting from changes in volume.

VOLUME ADJUSTMENT FORMULA

AIPI = IPI * VAF

Where:

AIPI = Allowable change in the prior year non-pass-through portion of the APRD after volume adjustment, expressed as a proportion. This is the adjusted IPI, which has not been annualized and does not include any CMAF or SIPTF.

IPI = Hospital Input Price Index.

$$VAF = \frac{DIS_P + (VC^* (DIS_F - DIS_P))}{DIS_F}$$

VAF = Volume Adjustment Factor

DIS_P = Total hospital discharges in the prior fiscal period (annualized if needed).

VC = Variable cost as a proportion of total cost for the prior fiscal period.

* = Multiplication.

DIS_F = Total hospital discharges in the settlement fiscal period (annualized if needed).

2) Each provider's total costs, except for pass-through costs, shall be divided into the fixed and variable components shown in the following table. Data from the provider's Medi-Cal cost report or in the event it is unavailable, other direct report of expenses, shall be used to estimate the percentage of a provider's cost which varies with volume. A fixed to variable cost ratio of 50:50 shall be used when sufficient data from the provider are not available.

Approach: Reimbursement to Out-Of-State Hospitals For Inpatient Services Provided to Medi-Cal Beneficiaries

I. General Principles

A. Reimbursement for out-of-state hospital inpatient services which have been certified for payment at the acute level and which are either of an emergency nature or for which prior Medi-Cal authorization has been obtained, shall be reimbursed and shall not exceed the current statewide average of contract rates for acute inpatient hospital services negotiated by the California Medical Assistance Commission or the actual billed charges, whichever is less.

B. Out-of-state hospitals may request an administrative adjustment to the rate within 60 days of notice of payment. The request, which must be in writing, to the Department of Health Services, Hospital Reimbursement Unit, 714 P Street, Room 1592, Sacramento, CA 95814.

C. The decision on the administrative adjustment shall be final and not subject to further appeal.

CLASSIFICATION OF FIXED AND VARIABLE COSTS

FIXED COSTS	VARIABLE COSTS
SALARIES AND WAGES	SALARIES AND WAGES
Management and supervision	Registered nurses
Technician and specialist	Licensed vocational nurses
Clerical and other administrative	Aides and orderlies
Physicians	Environmental and food Services
Nonphysician medical practitioners	Other salaries and wages
EMPLOYEE BENEFITS-Distributed proportionately according to salaries and wages	EMPLOYEE BENEFITS-Distributed proportionately according to salaries and wages
FICA	FICA
Unemployment insurance	Unemployment insurance
Vacation, holiday, and sick leave	Vacation, holiday, and sick leave
Group insurance	Group insurance
Pension and retirement	Pension and retirement
Workers' compensation	Workers' compensation
Other employee benefits	Other employee benefits
OTHER DIRECT EXPENSES	PROFESSIONAL FEES
Insurance	Medical
Other direct expenses	Consulting and management
	Legal
	Audits
	Other professional fees
	SUPPLIES
	Food
	Surgical supplies
	Pharmaceuticals
	Medical care materials
	Minor equipment
	Nonmedical supplies
	PURCHASED SERVICES
	Medical
	Repairs and maintenance
	Management services
	Other purchased services

3) A provider may submit additional data on the classification of fixed and variable costs for review by the Department with the AAR. If these alternative classifications and/or data are accepted by the Department, the provider shall continue to:

(a) Utilize these accepted classifications of fixed and variable costs in all FPEs.

(b) Submit to the Department, along with their filed cost report, any required data on fixed and variable costs necessary to do the alternative calculations for all subsequent FPEs. If the provider fails to supply the data with the cost report, they shall have their interim payments reduced by 20 percent. If the data has not still been supplied 60 days after the 20 percent reduction in interim payments begins, the provider shall have their interim payments reduced by 100 percent until the data are supplied. The provider shall be given 30 days advance notice to supply the required data before any reductions in interim payments are applied under this part of the Plan.

4) All providers must supply the data items for each FPE necessary to do the PIRL calculations. The data must be supplied as part of each provider's Medi-Cal cost report.

K. Summary of ARPDL formula for provider with full settlement and full prior fiscal periods:

(1) ARPDL = MCDIS *
(2) (((RENTS + LIC + PTAX + DEP + LEAS + INT + UTL + MPI) / THD) +
(3) (((PMIRL - (PMCDIS * (TPTCPP / PTHD))) / PMCDIS) *
(4) (((((PX1 * (MPFP / (GOEPP - TPTCPP))) +
(5) (PX2 * (OPFP / (GOEPP - TPTCPP))) +
(6) (PX3 * (FOODP / (GOEPP - TPTCPP))) +
(7) (PX4 * (DRUGP / (GOEPP - TPTCPP))) +

$$(8)\ \left(\left(\sum_{k=1}^{6} (PYH_k * CYHR_k) \Big/ \sum_{k=1}^{6} (PYH_k * PYHR_k)\right) *\right.$$

(9) (SWP / (GOEPP - TPTCPP))) +
(10) (((PYHT * CYBR) / PYB) *
(11) (PYB / (GOEPP - TPTCPP))) +
(12) (PXO * (OTCP / (GOEPP - TPTCPP)))) *

$$(13)\ ((DIS_p + (VC * (DIS_f - DIS_p)))/DIS_f)) *$$

$$(14)\ (((\sum_{i=1}^{n} DRGC_i) / MCDIS) / ((\sum_{j=1}^{n} DRGP_j)/ MCDISP))) +$$

(15) (STA + PI + SI))))

Where:

ARPDL = All-Inclusive Rate Per Discharge Limitation.
MCDIS = Medi-Cal discharges in the settlement fiscal period.
RENTS = Rental costs for the settlement fiscal period.
LIC = License fees for the settlement fiscal period.
PTAX = Property Tax expenses for the settlement fiscal period.
DEP = Total allowable Depreciation expenses for the settlement fiscal period.
LEAS = Lease expenses for the settlement fiscal period.
INT = Allowable Interest expense for the settlement fiscal period.
UTL = Allowable utility expenses for the settlement fiscal period.
MPI = Total Malpractice Insurance costs for the settlement fiscal period.
THD = Total hospital discharges for the settlement fiscal period.
PMIRL = MIRL (Lowest of rate, costs and charges) for the prior fiscal period.
PMCDIS = Medi-Cal discharges in the prior fiscal period.
TPTCPP = Total allowable pass-through costs for the prior fiscal period.
PTHD = Total hospital discharges for the prior fiscal period.
PX1 = Price index for medical professional fees.
MPFP = Allowable Medical Professional Fees for the prior fiscal period.
GOEPP = Gross Operating Expenses (GOE) for the prior fiscal period.
PX2 = Price index for Other Professional Fees.
ODFP = Allowable Other Professional Fees for the prior fiscal period.
PX3 = Price Index for Food costs.
FOODP = Allowable food costs for the prior fiscal period.
PX4 = Price Index for Drug costs.
DRUGP = Allowable costs for Drugs for the prior fiscal period.
PYH_k = Prior fiscal period hours paid for employee classification k.
$CYHR_k$ = Settlement Fiscal Period Hourly Wage rate for employee classification k.
$PYHR_k$ = Prior fiscal period Hourly Wage Rate for employee classification k.
SWP = Allowable costs for salaries and wages for the prior fiscal period.
PYHT = Prior fiscal period paid hours.
CYBR = Settlement fiscal period hourly benefits rate.
PYB = Prior fiscal period benefits.
PXO = Price Index for Other Costs.
OTCP = Other allowable costs for the prior fiscal period.
DIS_p = Total hospital discharges for the prior fiscal period.
VC = Variable cost proportion for the prior fiscal period.
DIS_f = Total hospital discharges for the settlement fiscal period.
$DRGC_i$ = DRG weight for patient i in the settlement fiscal period.
n = Number of DRG weights in the settlement fiscal period.
$DRGP_j$ = DRG weight for patient j in the prior fiscal period.
m = Number of DRG weights in the prior fiscal period.
MCDISP = Medi-Cal discharges in the prior fiscal period.

STA = Adjustment factor for Scientific and Technological Advancement.
PI = Adjustment factor for Productivity Improvement.
SI = Adjustment factor for Service Intensity.

Lines 2 through 15 are the ARPD = All-Inclusive Rate Per Discharge.
Line 2 is the PASPD = Pass-through cost per discharge.
Line 3 is the PNPARPD = Prior fiscal period Non-pass through MIRL Reimbursement Rate Per Discharge.
Lines 4 through 12 are the IPI = Input Price Index.
Lines 4 through 13 are the AIPI - Adjusted Input Price Index.
Lines 4 through 15 are the HCI = Hospital Cost Index.
Line 8 is the SWI = Salary and Wage Index.
Line 10 is the EBI = Employee Benefits Index.
Line 13 is the VAF = Volume Adjustment Factor.
Line 14 is the CMAF = Case Mix Adjustment Factor.
Line 15 is the SIPTF = Allowance for Service Intensity, Productivity, and Scientific and Technological Advancement Factor.

VI. ADMINISTRATIVE ADJUSTMENT PROCESS

A. A provider may request an AA to the ARPDL or PGRPDL established for that provider if the provider's cost based allowable reimbursement for the settlement fiscal period as defined by the lower of Section II A. 1) and 2) of this Plan, exceeds or are expected to exceed the PIRL by over $100. Expected to exceed only refers to the settlement period being issued and not any future settlement fiscal periods. The burden shall be on the provider to estimate, using the PIRL settlement information provided by the Department and any other information they may have, if they will expect to exceed the PIRL by over $100.

B. Items that are not subject to an AA or appeal include the following:

1) The use of Medicare standards and principles of reimbursement.

2) The reimbursement amounts determined in Section II A. 1) and A. 2) of this Plan.

3) The method for determining the IPI.

4) The use of all-inclusive reimbursement rates.

5) The use of a volume adjustment formula.

6) Disproportionate share payments (these are not reduced by application of the PIRL).

7) Data reported on the cost report which has been audited or reviewed by the Department or considered true and correct pursuant to W&I Code Section 14170. Data that was incorrectly transferred from the providers Medi-Cal cost or audit report and used to calculate the MIRL is subject to appeal.

8) The methodology used to calculate the interim rate.

9) Any prior fiscal period issues, including the base period.

10) Higher costs due to low occupancy.

11) Items not reimbursed as part of the Medi-Cal cost report process as determined in Section II A. 1) and A. 2) of this Plan.

12) Increased costs. Only the cause for the increased costs may be appealable, and then only if it is otherwise an appealable item.

13) Any issue raised in a previous formal appeal for which a decision was made by the Department for the same provider. The only exception is to incorporate into the settlement fiscal period PIRL the prior decision in the same manner as it was previously decided by the Department. These only include decisions made for FPEs affected by Parts I through XIII of this Plan. This does not include issues withdrawn by the provider and thus not determined on their merits in the formal decision.

14) Increases in average length of stay.

15) Changes in the Cost-Based Reimbursement System as determined under Section II A. 1) and A. 2) of this Plan.

16) Increased costs incurred by entering into a contract which did not contain reasonable cost increase limitations.